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Mitchell H. Katz, M.D.
Director of Health

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TO: Lee Ann Monfredini, President and Members of the Health Commission

FROM: Mitchell H. Katz, M.D. Director of Health

RE: Medicaid Demonstration Project – Feasibility Analysis

DATE: December 28, 1998

This report is designed to provide the Health Commission with a update on the Medicaid Demonstration Project (1115 Waiver). Specifically, this report will summarize the planning process to date and the 1115 Waiver feasibility analysis. This analysis was presented to the Medicaid 1115 Waiver Planning Committee on December 9, 1998. At this time, the Committee is not making a recommendation with respect to whether the City and County should proceed with a 1115 waiver. The Committee believes that additional work is needed before making any recommendation.

## MEDICAID DEMONSTRATION PROJECT (1115 WAIVER)

Section 1115 of the Social Security Act permits the Secretary of Health and Human Services (HHS) to authorize research and demonstration projects. The program provides the authority to waive many of the federal requirements that normally apply to states that receive federal funding for Temporary Assistance to Needy Families (formally AFDC), Medicaid and Title XX programs. The Health Care Financing Administration (HCFA) within HHS oversees the 1115 waiver demonstration process.

The 1115 waivers are generally reserved for unique demonstration projects. States have used the process to expand health care to uninsured populations, implement mandatory managed care programs for Medicaid recipients, and change reimbursement structures for providers, clinics and hospitals. Under President Clinton, there has been an increase in the number of states applying for and receiving 1115 waivers.

While California has experience with implementing 1915 waivers (two-plan model, Geographic Managed Care and County Organized Health Systems), it has limited experience with 1115 waivers. In 1996 the State obtained its first 1115 waiver to assist Los Angeles County in revamping its health care delivery system. Specifically, Los Angeles wanted to stabilize their safety net, reduce inappropriate hospital utilization, move towards outpatient delivery settings, preserve trauma and emergency care

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systems, and improve access. At the time, Los Angeles was facing over a $600 million deficit in its health department.

In the fall of 1996, the Department of Public Health submitted a proposed 1115 Waiver concept paper to the State Department of Health Services. In August 1997 the State gave San Francisco approval to initiate the development of a waiver based on their review of the concept paper. San Francisco did reserve the right to amend the concept paper based on subsequent input. The Department believes that developing programs to cost-effectively expand access and ensure quality care can have significant implications nationally. We are particularly interested in redesigning the public and private delivery systems to create a viable financing plan that supports a comparable and comprehensive scope of health benefits for Medi-Cal recipients and the uninsured.

## PLANNING PROCESS

On December 9, 1997, the Health Commission passed a resolution appointing a Medicaid 1115 Waiver Planning Committee to develop a plan for submitting a waiver and to provide input on key program and fiscal components. As dictated by the Health Commission resolution, the Committee was established with broad representation from the San Francisco community. The Committee held its first meeting in February 1998 and began meeting on an ongoing basis in April 1998. Attachment A is a list of the Committee members. In May 1998, the Department retained a consultant, Pacific Health Policy Group, which specializes in 1115 waiver development, to provide technical assistance to the Department in examining the appropriateness of a waiver for San Francisco.

### *A. Guiding Principles*

The Committee spent extensive time reviewing the guidelines of a 1115 waiver and summaries of other 1115 waivers that have been granted. Based on San Francisco's goals, key provisions of Medicaid demonstration projects and stakeholder interviews, the Committee adopted a set of guiding principles to use in determining the feasibility of pursuing a 1115 waiver. The goal and guiding principles (referred to below as objectives) are as follows:

GOAL: The Medicaid 1115 waiver proposal must improve access to care by addressing the following criteria:

- Expand health care coverage and provide access to regular primary and preventive care for the uninsured and other vulnerable populations;
- Increase community-based alternatives to institutional care in collaboration with the AB 1040 Long Term Care Integration Pilot Project;
- Develop alternatives to the existing two-plan model for Medi-Cal managed care;
- Expand the array of rehabilitation and personal home care services available to assist in the management of chronic disease.

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OBJECTIVES:

a) Ensure that any system changes maintain a viable safety net system.

b) Recognize that maintaining and improving community health status is a responsibility of the entire community.

c) Create broader participation by all San Francisco providers and businesses in the financing and delivery of health care on behalf of indigents and the uninsured.

d) Actively involve consumers and the provider community in the planning process in order to appropriately identify gaps in service and access needs.

e) Create strategies for using federal, State and local resources flexibly to eliminate barriers to the integration and coordination of a full continuum of health care services;

f) Offer a "seamless" comprehensive service delivery system which is community-based culturally-competent, linguistically-appropriate and enhances consumers' access to providers.

g) Only seek a Medicaid 1115 waiver which will result in improvements (either fiscal, programmatic, structural or in quality of care) in San Francisco's health care delivery system.

San Francisco's goals and guiding principles reflect San Francisco's desire to better facilitate and provide care to low-income and uninsured residents. These goals are based on the assumption that this can be accomplished by integrating care and the funding that supports care for those on Medi-Cal and those who are uninsured.

***B. Sub-Committee Structure***

During the planning process, three sub-committees were formed to assist the Committee in gathering information, and in analyzing policy and fiscal issues. Attachment A provides a list of sub-committee members. The sub-committees and their charges are described below:

- System Design -- This subcommittee was charged with evaluating how well Medi-Cal fee-for-service and managed care (i.e., the two plan model) are working in San Francisco with particular attention to the implications of incorporating the uninsured and the underinsured into the system. This subcommittee was also asked to assess whether it is desirable and feasible to refine the current model or develop a new one.

- Services Delivery -- This subcommittee was charged with reviewing the effectiveness and accessibility of the current Medi-Cal and indigent health care delivery system. It was asked to assess the need for system changes that would move service delivery away from the current institutional emphasis toward

community-based non-institutional care by enhancing the development of prevention, outpatient, support and home care services. The sub-committee is also addressing issues of barriers to care and consumer satisfaction including the cultural-competency, linguistic-appropriateness and distribution of services. Finally the sub-committee was charged with reviewing services to special high-needs populations (e.g., HIV/ AIDS) to determine whether certain populations or specialized services should be "carved out" of the waiver and addressed through other initiatives.

- Financing and Data -- This subcommittee was charged with advising on the development of the proposed waiver financial model by reviewing historical claims/eligibility data and developing projections for the waiver period and for the current system. The subcommittee was also asked to evaluate the impacts of proposed changes on current funding mechanisms and the two-plan model.

Attachment B is a summary document of the finding and policy directives issued by the Committee and its subcommittees. This information was used to shape the design of the feasibility analysis.

## SUMMARY OF FEASIBILITY ANALYSIS

Before beginning any work on the development of a Medicaid Demonstration Project (1115 waiver), it was first necessary to determine the feasibility of implementing such a waiver. Attachment C is a copy of the feasibility analysis presentation and Attachment D is a copy of the feasibility analysis report.

Several states have obtained 1115 Medicaid waivers which have allowed them to develop managed care programs and use the savings from converting to a managed care system to extend coverage to the uninsured. To determine if such a waiver could significantly advance San Francisco's efforts, an analysis of the number of uninsured to whom health coverage could be extended under a waiver and the costs that would be incurred in doing so was performed. The feasibility study is not intended to represent San Francisco's final program design for a 1115 waiver. It is designed to help San Francisco determine if it should proceed with developing a finalized concept paper and waiver for the State of California to submit to the Health Care Financing Administration. This feasibility analysis was conducted by our consultants, the Pacific Health Policy Group, in consultation with the Department of Public Health and the Medicaid 1115 Waiver Planning Committee.

It is important to recognize that any feasibility analysis is based on a set of assumptions about enrollment and expenditures under a proposed waiver. The assumptions are based on projections of current and anticipated utilization, expenditure and enrollment figures. As a result, the potential benefits of the waiver may be underestimated or overestimated. In conducting San Francisco's feasibility study efforts were made to err



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on the side of underestimating the potential benefit (i.e., underestimating the level of savings that can be realized).

### *A. Funding Availability*

The feasibility analysis indicates that San Francisco could generate savings through an 1115 waiver and use those savings to expand coverage to the uninsured. Waiver funding could come from the following areas over a five-year period:

- medical expenditure savings from enrolling SSI recipients in managed care ($71.10 million) and administrative savings from introduction of managed care ($4.86 million),
- allocation of one-half of San Francisco's Disproportionate Share Payments ($91.00 million) and
- allocation of one-half of San Francisco General Hospital's net SB 1255 revenues ($42.5 million).

The available funding over the five-year period is as follows:

TABLE 1
FUNDING AVAILABILITY

| Available Funding | FY 2000 | FY 2001 | FY 2002 | FY 2003 | FY 2004 | Five-Year Total |
|---|---|---|---|---|---|---|
| Savings | $5.8 mil | $9.9 mil | 14.8 mil | $19.8 mil | $25.6 mil | $75.9 mil |
| 50% DSH | $17.7 mil | $19 mil | $18.1 mil | $18.1 mil | $18.1 mil | $91.0 mil |
| *Sub-Total* | *$23.5 mil* | *$28.9 mil* | *$32.9 mil* | *$37.9 mil* | *$43.7 mil* | *$166.9 mil* |
| 50% SB 1255 | $8.5 mil | $8.5 mil | $8.5 mil | $8.5 mil | $8.5 mil | $42.5 mil |
| *Total* | *$32 mil* | *$37.4 mil* | *$41.4 mil* | *$46.4 mil* | *$52.2 mil* | *$209.4 mil* |

*i. SSI Recipients in Mandatory Managed Care ($76 million)*

The savings would be derived from mandatorily enrolling Medi-Cal recipients on SSI (Social Security Income) into a managed care system. Currently only TANF (Temporary Assistance to Needy Families) recipients are mandated to enroll into the Medi-Cal managed care two-plan model. SSI recipients on Medi-Cal are generally either aged, blind or disabled – this analysis is based only on enrolling the blind and disabled in managed care. On average this represents 25,727 SSI recipients annually over the five-year period.

Over a five-year period, approximately $76 million could be saved by enrolling these recipients into managed care systems. These savings would accrue above and beyond what would otherwise have been spent for providing health services to this population without a waiver. These savings are based on reducing current and/or projected reimbursement of services provided to this population. As the Health Commission is aware, Medi-Cal does not fully reimburse providers for the cost of caring for patients. As a result, the projected savings may further reduce Medi-Cal reimbursement that is seen as already below costs.



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However, this population was seen as the only area to obtain savings given California's current Medi-Cal program. Over the past two decades, California has reduced the increasing costs of its Medi-Cal program in three key areas: reimbursement, eligibility and scope of benefits. California has essentially reduced that amount of money it contributes (and therefore can obtain from the federal government in matching funds) by:

- reducing the amount of money it pays providers: introduction of selective hospital contracting, Medi-Cal managed care for TANF recipients and no cost-of-living increases for fee-for-service payments,

- restricting Medi-Cal eligibility: this relates solely to State-only funded Medi-Cal eligibility (e.g., shifting the Medically Indigent Adult system to the counties, attempts to defund prenatal care to undocumented women, etc.) and

- narrowing the benefits it will pay for: not paying for such services as IMDs (Institutes for Mental Disease).

Because of measures such as these, California ranks among the lowest states in terms of the level of Medicaid spending per beneficiary. The SSI population is one of the few areas remaining in which program reforms have not been made. This is particularly important given that the projected expenditures for the blind and disabled Medi-Cal recipients totals $709 million over the five years of the waiver – which is 75% of the projected medical expenditures for the Medi-Cal population included in the analysis. The managed care system would be a combination of primary care case management and pre-paid health plans.

*ii. Allocate 50% of San Francisco's DSH Payments ($91.00 million)*

In addition to savings generated from the enrollment of certain SSI recipients into managed care systems, the feasibility analysis assumes that 50% of San Francisco's disproportionate share hospital net payments could be funneled into the waiver. This was done because a portion of the uninsured population that is currently being served by these institutions would receive coverage with the savings identified by enrolling some SSI recipients into managed care. Because disproportionate share funds are currently matched on the federal level, including them in the waiver does not represent new funding, but indicates that the funds will help finance expanded eligibility for health coverage. The $91 million figure is based on DSH funds received at both San Francisco General Hospital and St. Lukes Hospital. Concern has been expressed that inclusion of such funding would jeopardize the continued existence of a viable safety net system to care for the indigent and those with multiple health and psychosocial needs.

*iii. Allocate 50% of San Francisco General Hospital's SB 1255 ($42.5 million)*

The analysis assumes that a portion of the SB 1255 net revenues that are received by the Department of Public Health for San Francisco General Hospital could be devoted to the waiver. The Department was unable to obtain the SB 1255 revenues for St.

Lukes Hospital to include the figures in this component of the funding analysis as was done with DSH (SB 855) revenues. As with the DSH funding, concern was expressed about the ability to preserve the safety net if these funds are included.

***B. Services Provided Through the 1115 Waiver***

The feasibility analysis incorporates a broad array of services, including acute physical health care, rehabilitation services, hospice and case management. By including a comprehensive array of services and the related revenue sources, the City and County can increase its ability to reallocate funds within the health system as reforms are undertaken. Savings which result from reductions in one area (e.g., inpatient hospital care) can be reallocated to service categories that should receive increased emphasis (e.g., preventive services). Additionally, the City and County can make new investments in primary care and community-based health care services and programs, with the intent of improving health outcomes in the community over the long term. Medi-Cal funded services included in the financial analysis were:

TABLE 2
SERVICES PROVIDED

| | | |
|---|---|---|
| • Physician services | • Organized outpatient clinics | • Pharmacy |
| • County and community hospitals | • Dentistry | • Optometry |
| • Podiatry | • Chiropractic | • Home health agency |
| • Hemodialysis | • Rehabilitation facility | • Other non-long term care |

The financial analysis does not include behavioral health services funded by Short-Doyle Medi-Cal, State Realignment and other designated mental health funding streams. It was felt that since the City and County has only recently begun its managed behavioral health program (i.e., the San Francisco Mental Health Plan) and because there has not been sufficient time to learn how the new system will affect utilization and costs, behavioral health should be excluded. However, should mental health services later be incorporated into an 1115 waiver, it is assumed that the associated funding would remain dedicated to behavioral health and would not be shifted to physical health. As a result, the outcome of any physical health care financial analysis would look the same with or without mental health funding.

Finally, long-term care services, except hospice, were excluded from the analysis since the beneficiaries receiving these services were not included. This was done in recognition of the City and County's Long Term Care Pilot Project Task Force which is working collaboratively with the State to develop an integrated long-term care program for this population. Medi-Cal eligibles needing long-term care services would receive services from the long-term care agency that would be developed under this project.

### C. Populations Included within the Waiver

An estimated 130,000 San Franciscans lack health care coverage. With the savings and reallocations identified in the fiscal analysis, these dollars can be allocated to provide coverage to uninsured individuals and thereby reduce the number of San Franciscans who lack coverage.

#### i. Hypothetical Medi-Cal Eligibles (12,281 uninsured persons)

In some 1115 waivers, states have been permitted to include in their expenditure and enrollment projections the cost of providing medical assistance to persons who could have been covered under Title XIX (Medicaid) through their state's Medicaid Plan Amendment. Such populations are generally known as hypothetical Medi-Cal eligibles since the states can cover such individuals without obtaining a 1115 waiver. The feasibility analysis extends coverage to two groups of "hypotheticals":

- uninsured children up to age 18 in households with income up to 300% of the federal poverty level (an estimated 1,927 children) and
- working parents of Medi-Cal eligible children who may have a portion of their income disregarded for Medi-Cal eligibility purposes (an estimated 3,992 adults).

For this population, State and/or County dollars will be necessary to cover one-half of the costs of these children and adults. The costs to the State and/or County would be approximately $3 - $3.5 million per year. Under the feasibility analysis, the SB 1255 dollars would be used as the State and/or County match for this "hypothetical" Medi-Cal population.

Also included in this category are Medi-Cal eligible children who are currently at or below 100% of the federal poverty level, but are not enrolled in the program. An estimated 2,176 children may be in this category. Finally, the analysis proposes the inclusion of the Healthy Families population into the demonstration project to minimize confusion over the various coverage programs, eligibility, enrollment and outreach efforts. The analysis assumes that roughly 4,200 children are eligible for the program.

It should be noted that the Health Care Financing Administration has not previously approved the inclusion of "hypotheticals" in a state waiver that did not cover all regions of the state. In addition, none of the funds identified in Table 1 on page 5 would be used for this population. As Medi-Cal elgibles, these "hypotheticals" would have a portion of their benefits covered by new federal Medicaid funding.

#### ii. Expansion Scenarios

Based on recommendations from the Waiver Planning Committee and the consultants, the following four expansion scenarios -- that is, populations that could be provided health care coverage under the waiver -- were developed:

- Scenario 1: Extends coverage to the general uninsured adult population, starting with the lowest income individuals and adding enrollees until funds are exhausted

- Scenario 2: Targets a portion of the expansion dollars towards persons with HIV/AIDS who are uninsured/underinsured for prescription drug coverage and use the funds to purchase protease inhibitor drug therapy coverage for these individuals. This scenario continues to set aside a portion of the expansion dollars to extend coverage to the general uninsured adult population.
- Scenario 3: Extends comprehensive medical coverage to uninsured persons with AIDS. Because of their relatively high costs, this scenario devotes all expansion dollars to this group so that a meaningful number can be covered
- Scenario 4: Extends coverage to the general adult uninsured population, but also targets outreach to identify and enroll uninsured persons with high medical needs (including individuals with HIV/AIDS)

With respect to Scenario 2, the Medicaid 1115 Waiver Planning Committee believes that this scenario should not be considered fully given the existence of the AIDS Drug Assistance Program (ADAP). ADAP provides prescription drugs to lower income Californians who do not have access to Medi-Cal or private insurance with adequate prescription drug coverage. ADAP covers protease inhibitors. Additional information will be provided to the Committee on what prescription drugs are covered under ADAP since concern was expressed that ADAP does not cover all necessary drugs and that a number of HIV-positive individuals are low-income and uninsured. While the Committee is not fully considering this as an expansion scenario, the Department has provided the Health Commission with an idea of how many individuals might be served under this scenario and the other scenarios in Table 3.

Irrespective of the scenario chosen, each includes coverage of the "hypothetical" Medi-Cal eligibles, namely, children below 300% of the federal poverty level and certain working parents of Medi-Cal eligible children. Each scenario also reflects coverage under different funding levels. Specifically:

- with only projected savings from managed care for blind and disabled SSI recipients ($76 million over five years),
- with managed care savings and the inclusion of 50% of net disproportionate share revenues ($167 million over five years) and
- with managed care savings, 50% of net disproportionate share revenues and 50% of San Francisco General Hospital's SB 1255 net revenues ($209.5 million over five years).

Table 3 on the following page compares the number of individuals who could be covered in the first year of the waiver (fiscal year 2000) using the different funding scenarios.

TABLE 3
EXPANSION COVERAGE -- YEAR ONE OF WAIVER

| | Scenario 1: Coverage to Adult Uninsured | Scenario 2: Protease Inhib. Therapy & Coverage to Adult Uninsured | Scenario 3: Compreh. Coverage to Persons with AIDS | Scenario 4: Coverage to Adult Uninsured & Target Persons with High Needs |
|---|---|---|---|---|
| Hypotheticals | | | | |
| • Children | 8,289 | 8,289 | 8,289 | 8,289 |
| • Adults | 3,992 | 3,992 | 3,992 | 3,992 |
| Total Hypotheticals | 12,281 | 12,281 | 12,281 | 12,281 |
| General Uninsured | | | | |
| Savings Only | 3,100 | 2,325 | | 2,018 |
| Savings and DSH | 12,531 | 9,399 | | 8,158 |
| Savings, DSH & SB 1255 | 20,562 | 12,805 | | 11,115 |
| Protease Inhibitors | | | | |
| Savings Only | | 140 | | |
| Savings and DSH | | 566 | | |
| Savings, DSH & SB 1255 | | 772 | | |
| Comprehensive Coverage to Persons with AIDS | | | | |
| Savings Only | | | 242 | |
| Savings and DSH | | | 977 | |
| Savings, DSH & SB 1255 | | | 1,603 | |
| General Uninsured and Persons with High Needs | | | | |
| Savings Only | | | | 673 |
| Savings and DSH | | | | 2,719 |
| Savings, DSH & SB 1255 | | | | 3,705 |
| ***Total Coverage (For Each Scenario)*** | | | | |
| ***Savings Only*** | ***15,381*** | ***14,746*** | ***12,523*** | ***14,972*** |
| ***Savings and DSH*** | ***24,812*** | ***22,786*** | ***13,258*** | ***23,158*** |
| ***Savings, DSH & SB 1255*** | ***32,843*** | ***25,858*** | ***13,884*** | ***27,101*** |

Of the estimated 130,000 uninsured San Franciscans, a maximum of 32,843 (or 25%) could be provided health coverage during the first year of the waiver. However, this could only occur if a managed care system for blind and disabled SSI recipients is implemented, 50% of net DSH revenues are allocated and 50% of San Francisco General Hospital's SB 1255 net revenue are used -- $32 million. If only savings from the implementation of managed care are used, then during the first year, coverage could be expanded from 242 (Scenario 3) to 3,100 (Scenario 1) people depending upon the expansion scenario chosen.

### *D. County Organized Health System*

The feasibility analysis also discusses the appropriateness of developing a County Organized Health System model under an 1115 Waiver. As noted on above, the

System Design subcommittee was asked to assess whether it was desirable to refine the current two-plan model for Medi-Cal managed care or develop a new alternative Medi-Cal managed care system.

California currently has five county-organized health systems (COHSs) -- in Orange, San Mateo, Santa Barbara, Santa Cruz and Solano/Napa counties. COHSs contract with the Department of Health Services to provide Medi-Cal covered health care services to eligible recipients. Last year Representative Radanovich introduced H.R. 3014 which would allowed California to: (1) develop four additional COHSs and (2) increases the percentage of Medi-Cal recipients in the State who can be enrolled in COHSs from 10% to 20%. This bill was not passed.

Concern has been expressed that the two-plan model is not appropriate for San Francisco on the premise that it may be difficult for two competing health plans to maintain financial viability and provide services with a low number of mandatory Medi-Cal eligibles – 36,000 in San Francisco. There is also the believe that a COHS is a more appropriate Medi-Cal managed care model because it will also for the creation of on comprehensive health care delivery system for all Medi-Cal recipients. A COHS will allow for continued provider choice by beneficiaries and still enable the State to continue its transition of Medi-Cal recipients into managed care systems. San Francisco's development of a COHS would continue to afford the State's current health plan contractors an opportunity to participate.

The feasibility analysis indicates that an 1115 Waiver could be designed to operate as a COHS. The City and County would need to create an administrative structure which operates as a health authority through which all eligible are enrolled in various types of managed care programs. With such a model, the federal government would be concerned about the preservation of enrolled choice under a single health care authority model. However, if the range of service delivery options is available, then the County should be able to demonstrate adequate choice.

While a COHS can be developed in two manners, either through federal legislation and subsequent State authorization, or via an 1115 waiver, the flexibility granted under the mechanisms differs. If the COHS is developed via federal legislative authority, then it is restricted to using any Medi-Cal savings (either in medical expenditures or administration) on the Medi-Cal population. The COHS could re-invest the savings to increase Medi-Cal provider reimbursement or to expand services to the Medi-Cal population, for example. However, if an 1115 waiver develops a COHS structure and the waiver seeks to expand coverage to the uninsured, then Medi-Cal savings can be used to increase Medi-Cal provider reimbursement, expand services to the Medi-Cal population and/or provide coverage to the uninsured individuals ineligible for Medi-Cal.

***E. Medicaid 1115 Waiver Planning Committee Response to Feasibility Analysis***

As mentioned previously, the Medicaid 1115 Waiver Planning Committee created by the Health Commission received a presentation on the feasibility analysis in early

December. Committee members raised questions concerning the assumptions made for the feasibility analysis, such as the ability to achieve the Medi-Cal cost savings, enrollment projections under the waiver, and the exclusion of behavioral health and long-term care from the model.

In order to determine whether the City and County of San Francisco should proceed with developing a waiver the Health Commission and the Committee must answer the following questions. All of these questions should be answered in the affirmative if San Francisco is to proceed.

- Is mandatory enrollment of the blind and disabled SSI population justified in terms of making available significant dollars for expanding health coverage to the uninsured?

- Would the total funds expected to be available for expanding health coverage (from the SSI conversion and other sources) allow San Francisco to cover enough individuals to make pursuit of a waiver worthwhile?

- Would development of the waiver under the proposed funding mechanisms continue to preserve a safety net system?

- Can all this be done while staying within the Health Care Financing Administration's budget neutrality limits for demonstration waivers?

As the Committee reviewed these questions, it also attempted to determine whether the study supported the Medicaid 1115 Waiver guiding principles adopted early in the planning process. The feasibility analysis should support the guiding principles adopted by the Medicaid Waiver Planning Committee. In examining the guiding principles, if the feasibility analysis does not support a principle, then we must determine whether not meeting that principle is a critical flaw in the proposed project. With respect to the four questions posed above, Committee members raised the following concerns:

- Managed Care System: The Committee felt that it was unable to either support or oppose this recommendation without the perspective of blind and disabled Medi-Cal recipients who would be directly affected by this proposal. While the Committee and sub-committees had representation from individuals who either provide services to this population or who are recipients, it was felt that specific focus groups and working sessions were needed before this recommendation could be fully evaluated.

- Sufficient Expansion: The level of expansion (in terms of the number of uninsured that can be offered health care coverage) is dependent upon the level of funding available in the waiver. If only savings from implementing managed care for blind and disabled SSI recipients is used for the expansion, then the number of uninsured people that can be covered will be 3,100 in the first year and 11,796 in the fifth year of the waiver. Committing all the funds identified in the waiver will yield 32,843 in the first year and 39,823 in the fifth year under Scenario 1 that expands coverage to the

most number of uninsured. The City and County must determine if the waiver expands coverage to a level making the waiver worthwhile to pursue.

- Safety Net: Some Committee members expressed concern over the inclusion of SB 855 and SB 1255 funds in the feasibility analysis. These members are concerned that siphoning off a portion of the safety net funding will jeopardize the viability of the safety net system. Inclusion of these funds may prevent the Committee from meeting its first guiding principle: to "ensure that any system changes maintain a viable safety net system." However, not all members expressed this view. Some members felt that the inclusion of SB 855 and SB 1255 funding was appropriate in order to obtain a complete picture of available Medi-Cal funds. In addition, some members felt that State Realignment and City general funds should also be included in the financial analysis under the assumption that all funding which supports services to the uninsured should be included. The financial analysis did not include State Realignment and City general funds because the budget neutrality provisions relate to Medicaid funds. The City and County does not need a waiver to use its local funds and State Realignment funds differently.

- Budget Neutrality: The Committee was unable to address this question since the budget neutrality provisions are jointly agreed upon by the federal government, State and locality based on the waiver provisions dictated by the Health Care Financing Administration.

In addition to the issues cited above, Committee members are interested in having a better understanding of how the 1115 Waiver planning relates to other health initiatives within the City and County. As the Department indicated to the Health Commission previously, in the absence of official notification from the State regarding the August 1996 concept paper we felt that it was imperative to begin individual planning efforts to improve aspects of our delivery system. When the Health Commission approved the creation of a Medicaid 1115 Waiver Planning Committee, the City was in the midst of planning for a number of health initiatives – Long Term Care Pilot Project, Mayor's Blue Ribbon Committee on Universal Health Care and County Organized Health System -- all of which are designed to either improve access or expand coverage. The Department explicitly stated that at that time we were looking at a number of different avenues to improve the delivery of health care to Medi-Cal recipients and the uninsured. At the time, we realized that a number of the planning efforts intersected in some respects.

However, with the completion of this feasibility analysis, the development of a draft concept paper for an integrated long-term care service delivery system and the passage of Proposition J to expand health care coverage we must address the apparent redundancy in these efforts. Several Committee members have expressed interest in knowing how the Department's recent policy on increasing alternatives to institutionalization relates to the work being done by the Medicaid 1115 Waiver Planning Committee. San Francisco must clearly define and focus on a comprehensive health planning initiative.

The Committee believes strongly that it cannot make a recommendation on either proceeding with or abandoning the waiver absent a larger planning process which examines all health planning efforts in the City and County and how they do or do not intersect. Once this is accomplished, the Committee will be in a better position to make a recommendation to the Health Commission for its consideration.

## NEXT STEPS

The Committee and its sub-committees have spent a significant amount of time learning about the Medi-Cal program and Medicaid demonstration projects. At this time, the Committee cannot make a recommendation to the Health Commission concerning the appropriateness of proceeding with the development of an 1115 waiver for the City and County of San Francisco.

The Committee felt strongly that we should not proceed without additional input from Medi-Cal recipients on SSI. The concerns of this population regarding managed care are clearly of great importance. The Department also believes that we should proceed on our long-term care planning, as well as, evaluate the San Francisco Mental Health Plan prior to making a final determination as to whether we will pursue an 1115 Waiver. In addition, the Department believes that we should continue to pursue an alternative Medi-Cal managed care model such as a County Organized Health System. Several counties have indicated their interest in working together to re-introduce another COHS bill on the federal level in early 1999.

The Department recommends that we come back to the Health Commission with a follow-up 1115 Waiver report. The report would be presented as soon as the Department has additional feedback from SSI recipients on this proposal, and has more information on our long-term care planning efforts, the development of COHS bill for 1999 and the implementation of the Mayor's Blue Ribbon Committee on Universal Health Care recommendations.